HIPAA Applicability – *Are you a Covered Entity?*

Including Transactions and Privacy Final Rules

One of the main decisions related to HIPAA is whether or not a program is a Covered Entity. If a program is a Covered Entity then there may be HIPAA requirements that need to be met. It should be noted that even if a program is not a Covered Entity, changes may be required if their business partners change the data collected in their efforts to conform to HIPAA. Some examples of this may be race–ethnicity codes (HIPAA only uses 8 codes and some State programs use 58), provider numbers (HIPAA uses different provider types), and Diagnosis Codes (HIPAA uses ICD 9 that may not include special program codes and other codes in use). If a program is not a Covered Entity, the HIPAA rules do not apply to it except that some view HIPAA rules as setting best practice standards for privacy, security and other processes. Also, programs may need to work with their legal staff to document decisions related to Covered Entity status and what requirements need to be met.

Requirements: Overall, if you are a Covered Entity, you must:

1. Protect the privacy of individually-identifiable health information, as provided in the Privacy Rules, and
2. Use only the Standard Transaction format/content for any of the Covered Transactions that you exchange electronically (by any electronic methodology, including but not limited to file transfers, voice response, web-based entry, and other technologies). See the definitions of the Covered Transactions in the Health Care Provider column (boxes 2c – 12c) below.

To determine if you are a Covered Entity, follow the definitions of each Covered Entity that are given in the chart below:

?? If your organization is described in any of boxes 1.0a through 17a, and is NOT described in boxes 18a through 23a, you are a Health Plan.

?? If your organization is described in boxes 1.0b and 1.1b, you are a Health Care Clearinghouse.

?? If you or your organization is described in boxes 1.0c, and you provide health care services as described in 1.1c, and you electronically conduct any of the transactions listed in 2c through 12c, you are a provider. Remember that "electronic" conduct of any of the transactions includes not only file transfers (as are usually done with claims submission), but all other non-paper, non-human-based means of communication. For example, if you use the Voice Response or card-swipe units to check a member's eligibility, you are conducting an electronic transaction.

There may be "Covered Entity" functions within a department/program; each of these components should be evaluated separately, according to their respective functions. If the component that provides the services is not itself a separate entity, then the entity to which it belongs is a HIPAA "hybrid entity." HIPAA's rules apply to the component that performs the covered function. The importance of being a hybrid entity is that HIPAA requires you to build walls between the covered functions and the rest of the entity, so that the non-covered portions do not have access to Protected Health Information.

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
1.0	A Health Plan is an individual or group plan that provides, or pays the cost of, medical care. Health Plans are further defined in lines 1.1a through 17a. Specific exclusions are given in blocks 18a through 23a below. *Be sure to check the exclusions in blocks 18a through 23a before you make your decision.*	A Health Care Clearinghouse is a public or private entity, including a billing service, re-pricing company, community health management information system or community health information system, and "value-added" networks and	A Health Care Provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter is a Covered Entity. Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
		switches, that does either of the following functions:	section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.
1.1	A group health plan [defined as an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan.	(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.	Health care means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following: (1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
2	A health insurance issuer [defined as an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.]		**§ 162.1101 Health care claims or equivalent encounter information transaction.** The health care claims or equivalent encounter information transaction is the transmission of either of the following: (a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care. [Claim] (b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care. [Encounter]

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
3	An HMO [defined as a federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.]		**§ 162.1201 Eligibility for a health plan transaction.** The eligibility for a health plan transaction is the transmission of either of the following: (a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee: (1) Eligibility to receive health care under the health plan. (2) Coverage of health care under the health plan. (3) Benefits associated with the benefit plan.
4	Part A or Part B of the Medicare program under title XVIII of the Act.		(b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.
5	The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.		**§ 162.1301 Referral certification and authorization transaction.** The referral certification and authorization transaction is any of the following transmissions: (a) A request for the review of health care to obtain an authorization for the health care. (b) A request to obtain authorization for referring an individual to another health care provider. (c) A response to a request described in paragraph (a) or paragraph (b) of this section.
6	An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).		**§ 162.1401 Health care claim status transaction.** A health care claim status transaction is the transmission of either of the following: (a) An inquiry to determine the status of a health care claim. (b) A response about the status of a health care claim.
7	An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.		**§ 162.1501 Enrollment and disenrollment in a health plan transaction.** The enrollment and dis-enrollment in a health plan transaction is the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
8	An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.		**§ 162.1601 Health care payment and remittance advice transaction.** The health care payment and remittance advice transaction is the transmission of either of the following for health care: (a) The transmission of any of the following from a health plan to a health care provider's financial institution: (1) Payment (2) Information about the transfer of funds. (3) Payment processing information.
9	The health care program for active military personnel under title 10 of the United States Code.		(b) The transmission of either of the following from a health plan to a health care provider: (1) Explanation of benefits (2) Remittance advice.
10	The veterans health care program under 38 U.S.C. chapter 17.		**§ 162.1701 Health plan premium payments transaction.** The health plan premium payment transaction is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan: (a) Payment (b) Information about the transfer of funds. (c) Detailed remittance information about individuals for whom premiums are being paid.
11	The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)(as defined in 10 U.S.C. 1072(4)).		(d) Payment processing information to transmit health care premium payments including any of the following: (1) Payroll deductions (2) Other group premium payments. (3) Associated group premium payment information.
12	The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.		**§ 162.1801 Coordination of benefits transaction.** The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care: (a) Claims (b) Payment Information
13	The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.		

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
14	An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.		
15	The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.		
16	A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals. [High-risk pools, as described in this rule, do not include any program established under state law solely to provide excepted benefits. For example, a state program established to provide workers' compensation coverage is not considered a high-risk pool under the rule.]		
17	Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).		
18	*Excluding workers' compensation and automobile insurance carriers, other property and casualty insurers, and certain forms of limited benefits coverage, even when such arrangements provide coverage for health care services.*		
19	*Excluding issuers of nursing home fixed-indemnity policies*		
20	*Excluding any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits (my note: such as workers' comp) that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and*		

	(a) Health Plan	(b) Health Care Clearinghouse	(c) Health Care Provider
21	*Excluding any government-funded program (other than one listed in paragraph (1)(i)-(xvi) of this definition) whose principal purpose is other than providing, or paying the cost of, health care [but which do incidentally provide such services. For example, programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Food Stamp Program, which provide or pay for nutritional services, are not considered to be health plans.]*		
22	*Excluding any government-funded program (other than one listed in paragraph (1)(i)-(xvi)of this definition) whose principal activity is (1) The direct provision of health care to persons; or (2) The making of grants to fund the direct provision of health care to persons. Examples include the Ryan White Comprehensive AIDS Resources Emergency Act, government funded health centers and immunization programs. (Note: Some of these may meet the rule's definition of health care provider.)*		
23	*Excluding agencies that determine eligibility for or enrollment in a health plan that is a government program providing public benefits (such as Medicaid or SCHIP) when that agency is not the agency that administers the program. For example, an agency that is not otherwise a Covered Entity, such as a local welfare agency, is not considered to be a Covered Entity because it determines eligibility or enrollment or collects enrollment information as authorized by law. We also do not consider the agency to be a business associate when conducting these functions.*		